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ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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March 3, 2026

The Honorable Gavin Newsom
Governor
State of California
1021 O St., Ste. 9000
Sacramento, CA 95814

Ms. Kim Johnson
Secretary
California Health and Human Services Agency
1215 O St.
Sacramento, CA 95814

Dear Governor Newsom and Secretary Johnson:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce (Committee) writes to request information related to program integrity and fraud, waste, and abuse (FWA) in your state's Medicaid program.

Recent reports and law enforcement actions have exposed unprecedented levels of Medicaid fraud in the State of Minnesota and other states. The magnitude of the fraud demands states proactively address FWA in Medicaid programs.[1] The swath of criminal schemes coming to light in Minnesota include overbilling, falsifying records, identity theft, and phantom claims in Medicaid social service and health programs for the elderly and disabled, children with autism, people struggling with substance use disorders, and homelessness.[2] The Committee is concerned that your state's Medicaid programs may be similarly vulnerable to FWA that harms Medicaid enrollees, legitimate providers, and taxpayers. To inform the Committee's oversight and potential legislative reforms, we are examining Medicaid program integrity and actions your state has taken, and is taking, to proactively identify and root out FWA.

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, California Medicaid (Medi-Cal) spending surpassed $157 billion (over $97 billion in federal funding) and covered about 13.5 million people.[3] In fiscal year 2025, Medi-Cal, California's Medicaid program, is estimated to cost over $188 billion.[4] California broadly defines Medicaid eligibility and Medi-Cal's multi-billion dollar budget shortfalls are partly driven by the state's expansion of Medi-Cal health care coverage to illegal immigrants aged 26 to 49.[5] Medi-Cal also administers several Medicaid programs that are considered high risk for FWA.[6] In California, these include home and community based services (HCBS), such as the In-Home Supportive Services (IHSS) program, in addition to home health and hospice.[7] On January 27, 2026, the U.S. Centers for Medicare and Medicaid Services (CMS) Administrator, Dr. Mehmet Oz, wrote to you, requesting more information about "program integrity, eligibility verification, and provider oversight within California's Medi-Cal program," including concerning trends in the IHSS program, home health, and hospice.[8]

The IHSS program, which operates under Medi-Cal as an in-home assistance benefit to "eligible aged, blind, and disabled individuals," has experienced 348 percent growth in the last decade.[9] As part of sweeping indictments announced by the U.S. Department of Justice in the 2025 National Health Care Fraud Takedown, five individuals were charged for their role in fraudulent Medi-Cal billing for IHSS services.[10] These defendants are alleged to have submitted

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 45, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 26 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

[4] State of California Dep't of Health Care Services, Medi-Cal November 2024 Local Assistance Estimate for Fiscal Years 2024-25 and 2025-26, 2, https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2024_November_Estimate/N24-Medi-Cal-Local-Assistance-Estimate.pdf.

[5] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 18, 2026); Ana B. Ibarra, *California's Medi-Cal shortfall hits $6.2 billion with 'unprecedented' cost increases*, CAL MATTERS (Mar. 18, 2025), https://calmatters.org/health/2025/03/medi-cal-shortfall-worsens/.

[6] *See* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services at 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[7] *See* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* Colin May, *Home is not where the help is: Fraud in home health care*, Association of Certified Fraud Examiners (Mar. 2025), https://www.acfe.com/acfe-insights-blog/blog-detail?s=fraud-in-home-health-care; *see also* U.S. Centers for Medicare and Medicaid Services, Hospice Fast Facts (July 2025), https://www.cms.gov/files/document/cpi-hospice-fast-facts.pdf.

[8] Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Gavin Newsom, Governor of California (Jan. 27, 2026), https://leadingage.org/wp-content/uploads/2026/01/HHS-Letter-012726-Gov-Newsom.pdf.

[9] California Dep't of Social Services, In-Home Supportive Services (IHSS) Program, https://www.cdss.ca.gov/in-home-supportive-services (last visited Feb. 18, 2026); *Id.*

[10] U.S. Dep't of Justice, 2025 National Health Care Fraud Takedown Case Summaries, https://www.justice.gov/criminal/criminal-fraud/health-care-fraud-unit/2025-national-hcf-case-summaries (last visited Feb. 18, 2026).

time sheets for services not rendered when recipients of the services were unable to receive care due to being admitted to care facilities, out of the country, incarcerated, or hospitalized.[11]

Home health care and hospice agencies are experiencing unprecedented growth rates in California, specifically Los Angeles (L.A.) County.[12] In January, the Committee, alongside the House Committee on Ways and Means, wrote to U.S. Department of Health and Human Services (HHS) Inspector General, T. March Bell, highlighting disturbing patterns in provider enrollment and suspected overbilling of both Medi-Cal and Medicare in home health and hospice.[13] Disturbing patterns include an explosion of home health and hospice agencies registered in L.A. County, "representing almost 9% of total FFS [fee-for-service] home health spending for the entire country, though comprising just 2% of national FFS enrollment."[14]

As part of the 2025 National Health Care Fraud Takedown, another six individuals, including two physicians, were indicted for their connection to an alleged $2.7 million Medi-Cal and Medicare hospice fraud scheme.[15] In this scheme, patients—who did not qualify for hospice because they were not terminally ill—were allegedly fraudulently enrolled in hospice with the intent to defraud Medi-Cal and Medicare.[16] Seven additional individuals were recently arrested in connection with $3 million in Medi-Cal and Medicare hospice fraud in Monterey County and are similarly alleged to have recruited and enrolled patients to hospice who were not eligible due to not having a terminal illness.[17] In 2024, eight individuals were indicted for their alleged participation in a home health scheme that defrauded Medi-Cal of nearly $60 million between 2016 and 2022.[18] One defendant, Gerardo Santillan, was previously excluded from participation in Medi-Cal due to prior fraud convictions, yet was able to establish other home health agencies and conspire with others to fraudulently bill Medi-Cal.[19]

At the Committee's request, CMS briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[20] The Committee's Subcommittee on Oversight and

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[11] *Id.*
[12] Letter from The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., to The Hon. T. March Bell, Inspector General, U.S. Dep't of Health and Human Services (Jan. 9, 2026), https://d1dth6e84htgma.cloudfront.net/1_9_2026_HHS_OIG_Letter_1_4ad020643d.pdf.
[13] *Id.*
[14] *Supra*, note 8.
[15] *Supra*, note 10.
[16] *Id.*
[17] Press Release, State of California Dep't of Justice, Attorney General Bonta Announces Seven Arrests for Hospice Fraud: My Office is On It! (Feb. 5, 2026), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-seven-arrests-hospice-fraud-my-office-it.
[18] Press Release, State of California Dep't of Justice, Attorney General Bonta Announces Indictment of Southern California Healthcare Provider for Medi-Cal Fraud of Nearly $60 Million (Sept. 18, 2024), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-indictment-southern-california-healthcare.
[19] *Id.*
[20] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[21] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[22] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[23] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), non-emergency medical transportation (NEMT), HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.[24] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

> The concerns around these [ABA] services and misuse of millions of dollars of resources are discussed at every program integrity conference I've attended for the past several years. It should be on every state's radar; we started working ABA cases in the CHIP spaces 6 years ago. If a state isn't monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[25]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[26] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

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[21] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[22] *Id.*

[23] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

[24] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[26] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [27]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

1. What actions, if any, are being taken to identify, assess fraud risk, and investigate Medicaid fraud schemes that may be occurring in the state?

    a. Please provide all audits related to fraud, waste, and abuse in the state's Medicaid programs including audits completed by third-party contract auditors, from January 1, 2021, to present.

    b. Are any audits of the Medicaid program ongoing? If so, please detail the type of audits that are ongoing.

2. What program integrity measures are currently in place to prevent FWA in your state's Medicaid programs?

3. Describe the process for making criminal referrals for suspected Medicaid fraud to state, local, and federal law enforcement agencies.

4. What steps are being taken to sanction or disenroll fraudulent Medicaid providers? Please provide information about any sanctions or disenrollments of fraudulent providers, including all evidence supporting disenrollment proceedings.

5. How are Medicaid service providers screened for compliance with federal law?[28] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

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[27] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 11 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf.
[28] Screening levels for Medicaid providers, 42 C.F.R. § 455 subpart E (2011).

a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [29] If yes, please describe these processes.

b. How frequently are on-site visits conducted by your state for Medicaid providers by federal screening risk category (limited, moderate, and high-risk), including out-of-state providers?

c. Are any programs, provider types, or enrollment pathways exempt from on-site visits, and what statutory or regulatory authority permits those exemptions?

6. How does your state designate and evaluate risk level of provider types in the Medicaid program in accordance with 42 C.F.R. § 455 subpart E? Please provide the state's current Medicaid programs classified by screening risk level (limited, moderate, and high categorical risk).

   a. Have any Medicaid programs' categorical risk levels been reassigned since January 1, 2021? If so, please describe which program(s) were reassigned, including any supporting evidence that contributed to risk reassignment.

   b. How often does your state reevaluate Medicaid provider screening risk level?

7. Does your state collect data on Medicaid programs with abnormal or statistically significant increases in provider enrollment or claims over time, including programs which greatly exceed their estimated cost upon enactment?

   a. If so, please detail the programs that have experienced abnormal or statistically significant increases since January 1, 2021, the data that was collected on the programs, and how this data has been used to inform assessments of program vulnerability to FWA.

   b. Is your state utilizing innovative tools, including but not limited to identity verification, artificial intelligence, and data analytics, to detect irregular Medicaid claims activity? If so, please describe these tools.

   c. If you don't collect this data, why not?

8. Please provide information on active Section 1115 and 1915 demonstrations and waivers, from January 1, 2021, to present, including:

   a. program name;
   b. provider category risk level;
   c. effective date;

[29] *Id.*

d. spending;
e. enrollment;
f. services offered;
g. FWA measures; and
h. eligibility.

9. Please provide information regarding improper payments and recovery efforts in your state's Medicaid program, including:

    a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
    b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.
    c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.
    d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
    e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

10. Please provide information regarding screening, oversight, and enforcement actions related to Medicaid fiscal intermediaries, including:

    a. Screening, enrollment, credentialing, and monitoring requirements for fiscal intermediaries participating in Medicaid programs.
    b. Oversight mechanisms used to monitor caregiver time reporting, billing accuracy, and verification of services furnished through fiscal intermediaries.
    c. The frequency and scope of audits conducted on fiscal intermediaries since January 1, 2021, including audits conducted by the state or third-party contractors.
    d. The number of fiscal intermediaries that have been terminated, sanctioned, suspended, or otherwise subject to corrective action since January 1, 2021, and the basis for those actions.

If you have any questions about this request, please contact the Majority Committee Staff at (202) 225-3641.

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

John Joyce, M.D.
Chairman
Subcommittee on Oversight and Investigations

H. Morgan Griffith
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Committee on Energy and Commerce
The Honorable Yvette D. Clarke, Ranking Member, Subcommittee on Oversight and Investigations
The Honorable Diana DeGette, Ranking Member, Subcommittee on Health